Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000 (TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME *(If other than Veteran)* LAST NAME, FIRST, MIDDLE	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. *(Include ZIP Codes, and also a telephone number, if available)*	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. *(Include month and year)*	7C. CONDITION(S) *(Illness, injury, etc.)*

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM AT THE BOTTOM OF PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9B.

SECTION III - CONSENT TO RELEASE INFORMATION

READ BOTH PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9B.

9A. I, the undersigned, hereby authorize the hospital, physician or other caregiver shown in Item 7 to disclose and release to the Department of Veterans Affairs (VA) any information that may have been obtained in connection with physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. The responses which are submitted may be disclosed outside VA as permitted by law. I understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it will automatically end 180 days from the date I sign this form (block 10C).

9B. I (AUTHORIZE) (DO NOT AUTHORIZE) the above source to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Title 38 U.S.C. 7332. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self)*	10C. DATE

10D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	10E. TELEPHONE NUMBER *(Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS